STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the with the Investigation of Complaint IN00128406. This visit was in conjunction with the Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00127926. Complaint IN00128406: Substantiated-No deficiencies related to the allegations were cited. Survey Dates: May 1, 2, 3, 6, 7, 8, and 9, 2013 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410 Survey Team: Heather Tuttle, R.N. T.C. 5/1-5/3, 5/7-5/9/13 Regina Sanders R.N. Lara Richards, R.N. 5/2-5/3, and 5/7-5/9/13 Cynthia Stramel R.N. 5/2-5/3 and 5/7-5/9/13 Janelyn Kulik R.N. 5/6-5/7/13 Kathleen Vargas, R.N. 5/2/13 Census Bed Type: SNF/NF:77 Total: 77 Census Payor Source Medicare:9 Medicaid:54	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	**5025 MCCOOK AVE EAST CHICAGO, IN 46312**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Other:14 Total:77 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 16, 2013, by Janelyn Kulik, RN.	F 000		